SECTION 4

Tools, Resources and Modules

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TAB A

Tools and Worksheets

Tools and Worksheets

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Project Planning Form

The Project Planning Form is a useful tool for planning an entire improvement project, including a listing of all of the changes that the team is testing, all of the Plan-Do-Study-Act (PDSA) cycles for each change, the person responsible for each test of change, and the timeframe for each test. The form allows a team to see at a glance the overall picture of the project.

Use the Project Planning Form to help your team plan and keep track of an entire improvement project. At the start of the project, state the aim and the goal of the project. List the changes you are testing, and the PDSA cycles for each change. Assign an individual responsibility for each change. Estimate the time frame for each cycle. As the project continues, update the Project Planning Form.

This tool contains:

Project Planning Form

Example Project Planning Form: Asthma

Example Project Planning Form: Depression

Project Planning Form (cont.)

Project / Team:

Aim:

Measure(s):

Cycle No.	Change Tested	Person(s) Responsible	Week 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Project Planning Form (cont.)

Example: Project Planning Form – Asthma

Aim: To redesign our system of care for people with asthma to increase symptom free days by 30%, and increase patients on appropriate anti-inflammatory medication by 75% in pilot clinic *and in 4 satellite clinics.*

Measures (goals): 80% of patients will report a significant increase in symptom free days; 90% of patients will have an asthma action plan on the chart, 90% of patients will use a form of self-management at home, and patient satisfaction with asthma care will increase by 25%

Chronic Care Model Component: *Self-management Support*

Cycle No.	Change Tested	Person(s) Responsible	Week 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
1a	Implement follow-up for all of Dr. Martin's and Dr. Rowe's pts.	Ken, Sue	
1b "	Teach Self management follow up to next clinics	Sue	
2a	Implement Collaborative goal setting with all pts.	Dr. Smith	
2b	Modify process for collaborative goal setting and contracting and test for 5 patients	Dr. Jones, Sue	
2c	Implement contracting for Dr. Rowe's pts	Sue	
2d "	Teach contracting to all other Clinic Physicians	Clinic Director, Dr. Smith	
3 "	Expand use of Asthma Action Plan to all adult patients in Clinic B and C	Sue, Clinic Director	

Project Planning Form (cont.)

Example: Project Planning Form – Depression

Aim: To redesign our system of care for people with depression to achieve a 30% increase in the proportion of patients experiencing a major improvement in depressive symptoms after 12 weeks, and a 25% increase in the number of patients continuing depression treatment at 12 weeks after initiation, *in Medicine clinic and in three other primary care clinics (Family Practice, OB, Adolescent Med)*

Measures (goals): 75% of patients will have a structured diagnostic assessment, 80% of patients will have documented use of education materials, > 75% will have a follow-up assessment within 1st 8 weeks, and 60% of patients will have a 15 point decrease in PHQ-9 scores.

Chronic Care Model Component: *Practice Redesign*

Cycle No.	Change Tested	Person(s) Responsible	Week 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
1a	Expand use of red flags and structured assessment to Family Practice clinic	Rob, Dr. Johnson	
1b *	Assist with spread to other primary care clinics (OB, Adolescent Med)	Rob	
2a	Implement active follow-up to all of Medicine Clinic.	Lynn	
2b	Test active Follow-up in Family Practice	Sandy, Rob	
2c	Implement follow-up in Family Practice	Rob	
2d *	Assist w/ Spread: Teach process for active follow-up to other primary care clinics	Lynn	
3a	Implement Same Day consults for Medicine and Family Practice	Dr. Smith	
3b *	Spread: Teach to Test and try Same Day consults in other primary care clinics	Dr. Smith	

Adapted from the Institute for Healthcare Improvement

Defining the AIM

An aim is an explicit statement summarizing what your organization's pilot team hopes to achieve during the Collaborative. It helps to focus on specific actions to implement Self-Management Support, and to define which patients and providers will participate. Your pilot team's aim should also be time-specific and measurable.

In setting your team's aim, be sure to do the following:

1). *Involve the organization's senior leaders*
Leadership must align the aim with strategic goals of the organization. They should also help identify an appropriate patient population for the focus of the pilot team.

2). *Base the goals in your aim statement on clinical data and organizational needs*
Examine data within your organization. Refer to the goals in the Collaborative Goal statement, and focus on issues that matter.

3). *State the aim clearly and use numerical goals*
Teams make better progress when they have unambiguous, specific aims. Setting numeric targets clarifies the aim, helps to focus for change, and directs measurement. For example, an aim to "increase the percentage of patients with self-management goals by 50%" will be more effective than an aim to "improve patient self-management practices." A team's aim and numerical goals should be consistent with the charter.

In their aim statement, a team should have at least the required goals as outlined in the charter as well as others that they may wish to add. Good ideas for optional goals can be found by looking at the suggested optional measures in the measurement document.

If a team feels that the numerical goals outlined in the charter are too high for their organization to reach in this 8 month collaborative, they could choose to assess their baseline and then set a numerical goal that closes the gap by 50%. For example, if only 10% of a team's pilot population is currently receiving a self-management support component, then, for the purposes of the time frame of this collaborative, a goal of 55% would be acceptable (100%-10 %= 90%. Cut 90% in half = 45%, and add to 10% that is already baseline). Then in future time frames, a goal can be adjusted upward again by 50% of the gap.

4). *Include appropriate guidance on approaches and methods*
Describe the practice (office, clinic, practice team, etc.) and the patient population that will be the focus of this aim. Include specific strategies that the organization intends to follow, as well as target populations and office systems for spread of the Collaborative's work.

Team Management Planning Tool

Decisions to be made

In order to accomplish the work of the collaborative the team will need a time and place set aside to meet on a regular basis. These need to be determined at the first meeting, recognizing that you may need to revise the schedule as the work progresses.

Organizing Team Meetings

At the first team meeting, all members must agree on a set of ground rules on how the team and meetings will be run.

Basic Ground Rules:

- Attendance*:* a high priority is set on attendance. Discuss what legitimate reasons for missing a meeting are and establish a procedure for informing the team leader of the member's absence.
- Promptness: meetings start and end on time. Everyone is on time for meeting, but no waiting for anyone.
- Meeting time and place: specify a regular meeting time and place, establish a procedure for notifying members of the meetings.
- Participation*:* every team member's contributions are important; establish the importance of speaking freely and listening attentively.
- Basic conversational courtesies: listen attentively and respectfully to others, don't interrupt one conversation at a time, Team Leader holds the right to halt members who do not adhere to the rules.
- Assignments*:* since much of the team's work is done between meetings, members must be accountable for completing their assignments on time and report back to the team.
- Interruptions*:* based on the 100 mile rule determines when interruptions will be tolerated and when they won't.
- Rotation of chores: determine a rotation of routine housekeeping chores for all team members, so no one feels overwhelmed or stuck.
- Agendas, minutes, & records: although the Team Leader is ultimately responsible for these activities—others may be assigned the tasks, decide how these will be handled in your team.

Effective Discussion Skills for Team Members

- Ask for clarification—keep it simple and clear.
- Act as gatekeepers—no one dominates the discussion, expect equal participation among members.
- Listen—actively explore other's ideas rather than debating or defending each idea.

- Summarize—compile what has been said, restate it to the group with a question to check for agreement.
- Contain digression—disallow over long examples or irrelevant discussions.
- Manage time—stay on time with the agenda, if items go over recognize that others will be cut short.
- End the discussion—learn to tell when nothing further can be gained and end it.
- Test for consensus—state decisions made and check that team agrees.
- Constantly evaluate the meeting process—ask your selves: are we getting what we want from the discussion? If not, what can we do differently in the remaining time?

Team Meeting Agendas & Minutes

Record Keeping Systems

- Agendas: Purpose is to structure meeting, provide timeline for meeting and document topics of discussion at meeting. (See Attachments for Example.)
- Minutes: Purpose is to document discussion, actions, findings and decisions of team, as well as future actions required. (See Attachments for Example.)
- Provide historical information for future Teams looking at a similar process.

Best format is one that allows for documentation of:

- Topic discussed;
- Discussion;
- Conclusions/findings;
- Actions required;
- Responsible person; and
- State expected for completion of actions.

Project Notebook

Set up a notebook with these tabs:

- Team meetings: agenda for each meeting concurrently dated and signed minutes for each meeting.
- Project Aim
- Situation Analysis: demographics about the impact of Diabetes in your patient population.
- Data Collection & Analysis: File a copy of your monthly reports behind this tab.
- Project Plans and Action plans: For each action period you will be expected to develop plans for that action period and will revise it over the course of the action period file these here.
- Project Summary and Evaluation: Reports to the system leader and board of directors on progress file this here.

Sample Meeting Agenda Worksheet

Meeting Date:

Attendees

Agenda Topics

Agenda Topics	Leading Discussion	Time allotted

(1)

Discussion:

Conclusions:

Action items:	Person responsible:	Deadline:

(2)

Discussion:

Conclusions:

Action items:	Person responsible:	Deadline:

(3)

Discussion:

Conclusions:

Action items:	Person responsible:	Deadline:

Next Meeting Date and Time:

Senior Leader Monthly Report Form

I. Aim statement:

II. Description of pilot population: # of patients this month___

III. Measures:

Measure	**Definition of Measure**	**Goal**	**Data Collection Plan**

IV. Annotated run charts for key measures:

V. Brief description of key PDSA cycles:

VI. Summary of results:

Senior Leader Monthly Report – Sample Format

Report for the month of:_____

Aim: To redesign health center's systems to provide improved care to our patients with diabetes. We will accomplish this by making changes in the following areas: patient self-management, decision support, delivery systems, information systems, community relationships, and leadership. See our Key Measures descriptions below for specific goals.

Population of Focus: Although there are approximately 1,300 patients with diabetes in our 5 clinic area, we are going to focus our improvement work on the 1 centrally located clinic. Based on a billing review, we estimate that there were 225 patients with diabetes seen at this clinic by our two full-time providers in the last 2 years.

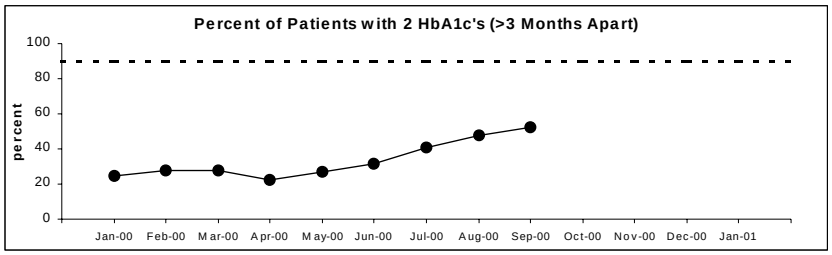
Note: If the registry does include information from 12 months before, then use whatever data exists up to 12 months back.

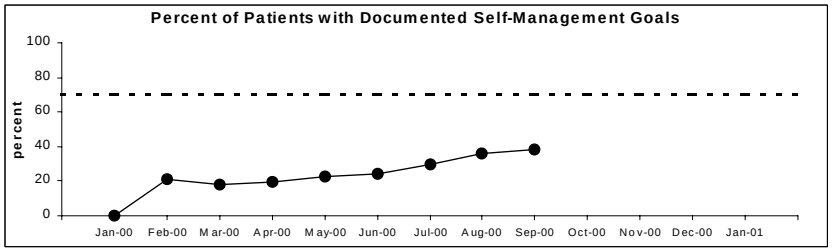
Measure	**Definition**	**Goal**	**Data Gathering Plan**
Percent of patients with two HbA1c's (at least three months apart) in last 12 months	Number of diabetic patients in the registry who have had two HbA1c's (at least three months apart) in last 12 months divided by the total number of diabetic patients in the registry. Multiply by 100 to get into percent.	90%	On the last work day of each month, the registry will be searched for all patients with a Dx of DM that have had two HbA1c within last 12 months (at least three months apart). Also, the total number of patients with a Dx of DM will be counted on the last work day of each month.
Percent of patients with documented self-management goals	Number of diabetic patients in the registry with documented self-management goals divided by the total number of diabetic patients in the registry. Multiply by 100 to get into percent.	70%	On the last work day of the month, the registry will be searched for all patients with a Dx of DM that have documented self-management goals set with a clinician. At the same time the total number of patients with a Dx of DM will be counted.
Average HbA1c	Average HbA1c value for patients in the Diabetes Registry	<8%	On the last work day of the month, find all patients with a Dx of DM in the registry, who have had an HbA1c in the last 12 months. Add all these patients' most recent HbA1c values together and then divide by the number of such patients.
Percent of patients with retinal exams in last 12 months	Number of diabetic patients in the registry who have had a retinal exam in last 12 months divided by the total number of diabetic patients in the registry. Multiply by 100 to get into percent.	70%	On the last work day of each month, the registry will be searched for all patients with a Dx of DM that have had a retinal exam within 12 months. Also, the total number of patients with a Dx of DM will be counted on the last work day of each month.

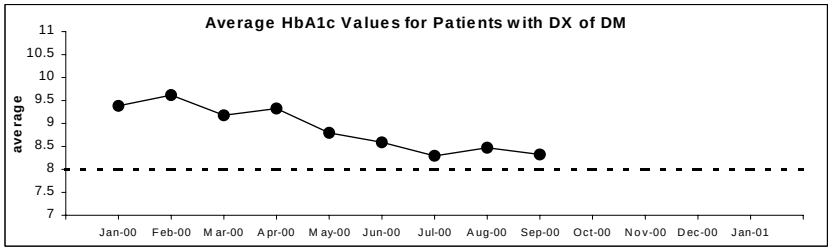
Description of Tests of Changes

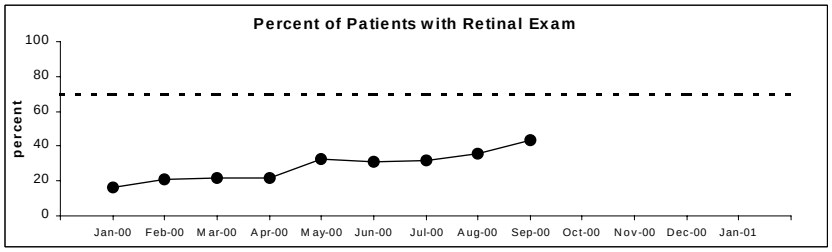
- *Categorize each test by the appropriate component of the Chronic Care Model.*
- *Make sure that you include only descriptions of cycles where changes to your system have been tested or implemented. Do not include meetings and other activities that your team is engaged in.*
- *Include enough detail so that the reader can determine what change was tested, when the test was done, how many patients were involved, who in your system was involved, what the results were, and what the next action is.*
- *There can be some overlap of these descriptions from month to month. However, there should be some information describing what happened since the month before (i.e. not just a repeat).*

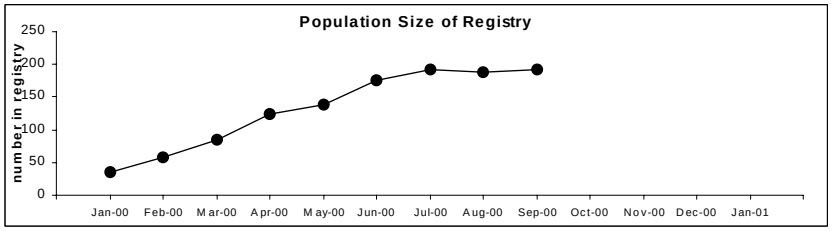
Summary of Results: *Integrate the learning and experience from testing changes described above. Describe the learning that has occurred and briefly indicate the next steps.*











Registry Assessment Tool

Name of Center :_____Contact Name:_____

Issue	Your Response
Who will be the leader for implementing the registry at your center as part your daily operation and work flow?	
Who will be the day-to-day person maintaining the registry at your center and training others the data entry process?	
How will data be collected?	
Who will input the data?	
How will the accuracy of data entry be checked?	
How will the registry be implemented in daily flow and practice?	
Where in the medical record will flowsheet be kept?	
How will electronic patient data be kept confidential?	
Who will have access to printing reports and viewing patient data?	
Is it possible to have electronic lab data/reports on daily, weekly or monthly basis?	
Do you believe that your center will want to use DEMS (or do you have an alternative electronic registry)?	
Can you envision a plan for how DEMS will be backed up (Weekly on a zip drive, LAN file, or floppy is recommended.)?	
Where in the clinical area will the computer and printer be stationed?	
What style of the DEMS flow sheet will be used? (See the DEMS User Manual for examples)	
Other issues?	

Computer Assessment Tool

Name of Center :_____Contact Name:_____

Hardware or Software Issue	Your Center's Status for this Issue
Do you have a computer that DEMS can be installed on and used daily for maintaining the registry?	
Does this computer have at least 32 MEG RAM and 20 Megabytes of disk space?	
Is the operating system on this computer Windows 95 (or higher)? If so, what version?	
Does this computer have Microsoft Access installed (Full install)? If so, what version?	
Do you have a color printer (or high quality laser printer) attached to this computer? If so, what is the make and model of the printer?	
Do you have on-site IS support at your center?	
Is this computer connected to the Internet (If not, is another computer connected to the Internet)?	
If you have an Internet connection, can you download files from the Web and can you receive attachments to e-mail messages?	
Does this computer have Excel (version 97 or higher) installed?	

Registry Evaluation Tool

Areas of Evaluation
Enter a single score for the complete area of evaluation; not for each item on the left

Score by Rating Each (1 through 10)
One being the WORST, Ten being the BEST)

1.	**User friendliness** a) Training time to learn b) Screen readability c) Navigation intuitiveness (is it easy to figure out where you want to go?) d) Application speed e) Are data query tools easy to use? f) Organization of content and variables i) can they be manipulated to produce personal settings? ii) is there a good overview of individual patient's care? iii) can groups of patients and their care be viewed? iv) are patient demographics gathered? g) Are software version updates easy to implement? Notes: Use this section to comment on your score and issues not addressed above.	
2.	**Specifications/Implementation Issues** a) Is the system **both** standalone and Web-based? b) Are data (stripped of identifiers) exportable to other software for analysis? c) Cost to implement (both financial and in terms of provider time) d) Level and cost of technical support e) Scalability (from one provider practice to large integrated delivery system) f) Is there ability to revise/access to source code? g) Data import capabilities from external & internal systems h) Data export capabilities to more full-functioned EMR i) Current user populations – dissemination to date? j) Can the application simultaneously support registries for multiple chronic diseases in the same patient population? k) Can the application be set up for multiple simultaneous users? l) Can it be set up for secure access via the Web? m) How stable is the application? n) Does implementation mean "touching" all workstations? o) Is there a commitment to build it using recommended IT standards? p) Can data be exported to other care providers for patient care purposes? Notes:	
3.	**Data Entry** a) How is access to data entry controlled? b) Ease of data entry/limitations on data entry sites c) Error check capabilities in key data fields **Notes:**	
4.	**Data Confidentiality** a) Are patient identifiers visible when looking at patient data? b) Is it completely HIPAA compliant? **Notes:**	

5.	**Decision Support** a) Are there reminder capabilities at the patient and population level? b) Is acting on reminders easy to do without delaying provider? c) Is there any order entry functionality? d) What diseases are supported by the registry? e) Is there access to guidelines or other protocols built into registry for these diseases? Is it easy to add further decision support functions? Notes:	
6.	**Individual Care Planning** a) Are there printable patient summaries that can be used at the time of a visit? b) Is there self-management support functionality and goal tracking variables? c) Can patient-friendly care plans be generated? d) Is there graphing capability of key clinical data? e) Can data be electronically shared in a secure and confidential manner with specialists and other members of a patients' care team? **Notes:**	
7.	**Population Care Planning** a) Is there ability to link to mailings (patient data load into letters and mailing labels generated) b) Can registry link to an email system for patient contact? c) Can subgroups within disease populations be identified? d) Can subgroups of co-morbid populations be identified? e) Can populations be stratified by disease severity? **Notes:**	
8.	**Feedback to Providers** a) Can reminders be displayed and printed for both patient and provider use? b) Can provider generate ad hoc reminders to support clinical/self-management care? **Notes:**	
9.	**Reporting Functions:** a) Can condition population reports be generated? b) Can provider-level reports be generated with comparators (other providers or regional data)? c) Are there statistical analysis capabilities around reports? d) Can exception reports for guideline-driven care be generated? e) Can an ad hoc data query be generated, allowing providers to monitor sub-groupings of patients? f) Is it easy to produce ad hoc reports? g) Can data be easily aggregated across sites for feedback to all providers or external reporting agencies? **Notes:**	
10.	**Development Capability & User Support** a) What is the ability of the organization to respond to the need for upgrades and changes? b) Are training utensils/programs/documentation offered? c) Is technical documentation offered for advanced users? **Notes:**	

Evaluating a Guideline Checklist

☐ Who developed the guidelines?

- Are the members of the guideline development team identified?
- Are all clinical perspectives represented?
- Are all cultural perspectives represented (e.g., African-American, Pacific islander)?
- Is patient input or participation documented?
- Are the sponsors of the guideline identified?
- Are there potential conflicts of interest?

☐ Why did they develop the guideline?

- Is there a clear statement of the guideline objective?
- Is the gap between current practice and outcomes and the recommended practice and outcomes clearly stated?
- Is the guideline development process described? (If so, what process was used?)
  - Explicit evidence-based (includes projections of healthcare outcomes for a defined population)
  - Evidence-based
  - Consensus process
  - Process of development not described

☐ What is the strength of the evidence?

- Is there a description of the strategy used to obtain information from the medical literature?
- Is there a description of the strategy used to critically appraise and synthesize the evidence?
- Is the evidence presented in terms of absolute differences in outcome (as compared to relative differences)?
- Are the major recommendations of the guideline based on high-quality evidence?

☐ Does the guideline possess the attributes of a good guideline?

- Are the patients that the guideline applies to clearly described and are exceptions stated?
- Is the guideline clear and brief?
- Does it provide genuine clinical guidance?
- Is it flexible (does it allow for the clinical judgment)?
- Can the change in care be measured?
- Can it be implemented in your care delivery system?
- Is the information the guideline is based on current?

☐ Has the guideline been successfully piloted or implemented?

Adopted from Improving Chronic Illness Care, 2005 http://www.improvingchroniccare.org

Evidence-Based Practice ~ Electronic Resources

There are several great sites created by professionals interested in evidence-based medicine. These sites can help you learn how to read studies, grade evidence, develop and/or evaluate guidelines. Note, most of these are not US sites.

Unit for Evidence-Based Practice and Policy
http://www.ucl.ac.uk/primcare-popsci/uebpp/uebpp.htm#How

Centre for Evidence-Based Medicine
http://cebm.jr2.ox.ac.uk/

Netting the Evidence
http://www.shef.ac.uk/~scharr/ir/netting/

New Zealand Guidelines Group
http://www.nzgg.org.nz

National Guideline Clearinghouse
Http://www.guideline.gov

Cochrane Reviews
http://www.cochrane.org/cochrane/revabstr/mainindex.htm

Adopted from Improving Chronic Illness Care, 2005 http://www.improvingchroniccare.org

Self-Care Treatment Plan

A Guide to working with your healthcare provider to improve your health and your healthcare experience.

- *Healthcare Education*
- *Goal setting based on your lifestyle*
- *Planned follow-up*

What can you do to make the Self-Care plan process work best for you?

- ***Ask Questions.*** *We want you to be successful with your healthcare treatments. Healthcare and treatment can be confusing. By answering your questions, your care provider learns more about you and can consider treatment alternatives.*
- ***Don't assume that your Care Provider has all the answers.*** ***You*** *are the most knowledgeable part of the team. Remember to think about all the areas listed on the previous page. If your treatment process is interrupting another important part of your life you need to talk about it.*
- ***Talk about what is working and not working in your treatment plan. You know most*** *about what may work best for you related to your treatment plans. You certainly know when a treatment is not working or creating other problems. Talk about these issues.*
- ***Keep follow-up appointments.*** *Follow-up appointments allow for you and your care provider to review the plan and make adjustments. If you need to be seen sooner call for a new appointment time.*

Care Providers at Ammonoosuc Community Health Services:

- *Dwight Eichelberger, MD*
- *Richard Covington, MD*
- *Genevieve Kelley, MD*
- *Philip Lawson, MD*
- *Shadan Mansoor, MD*
- *Pat Martin, CNMF*
- *Pat Kellogg, PAC*
- *Jessica Thibodeau, ARNP*

Other Resources to assist you with Self-Management of your health:

American Lung Association:
www.lungusa.org

Centers for Disease Control:
www.cdc.gov

US Dept of Health:
www.healthfinder.gov

Adapted from Ammonoosuc Community Health Services

What is a Self-Care Treatment Plan?

*-A Self-care treatment plan is a way for you to be more involved in decisions about your current health and treatments. Treatment decisions are made **with you** based on goals that are important to you.*

How will this care be different than healthcare I have had in the past?

*Changes you will see include an increased focus on **education** specific to your healthcare needs and more **goal setting** done with your input. Follow-up will include **review of your goals** as well as review of treatment effectiveness. **Follow-up** with you may also include phone calls for medication adjustments or support with your treatment plan.*

Why is Ammonoosuc supporting self-care?

Family Practice providers have long used the concepts of a self- care treatment plan to involve you in your care. We have learned that when you are involved in your treatment goals, you will do better over all with healthcare. In reality, we aren't starting something new but focusing closer on what we now know will work best for you.

Adopted from the Ammonoosuc Community Health Services

Health changes affect many areas of your life.

*Your care provider can provide you with the information you need about your health and treatment options **but just as important is the information you have about yourself, how your illness affects your life, and the questions you ask.***

The information you provide helps your healthcare provider consider treatment options that may fit better with your lifestyle.

The world of healthcare and medicine can offer many roads to improved health. The treatments offered are only as good as the outcomes for you and your own lifestyle.

-Relationships

- *Avoid Isolation*
- *Use Support Systems*
- *Social Activities*

Example: Talk with a friend 1-2 x/week.

-Health behaviors

- *Exercise*
- *Eating Well*
- *Getting Rest*

Example: Walk 15 minutes daily.

-Spirituality

- *Things you feel passionate about.*
- *Personal Beliefs*
- *Church or Faith Connection*
- *Meditation*

Example: Attend church services weekly.

Recreation/Hobbies

- *Self-Rewards*
- *Hobbies,*
- *Vacation and Travel*
- *Dining*

Example: Work on crafts for 1 hour daily.

-Productivity/Energy

- *Can you do the work you need or want to do?*
- *Volunteering*
- *Community/group project participation*
- *Caring for your family or home.*

Example: Wash and dry dishes daily.

-Medical Treatment plans

- *Following Treatment*

- *Taking Medications*
- *Keeping follow-up Appointments*

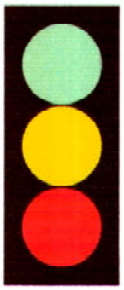
Does the treatment fit for you and your lifestyle?

Example: Take medication as directed.

Asthma Action Plan for Patient Self-Management

Asthma Action Plan

Name:	Date:
Medical Record #:	HHC Phone #: 503-3000
Patient Goal:	
Important! Your triggers to avoid:	



The colors of a traffic light will help you use your asthma medicines.

Green means **Go Zone!**
Use preventive medicine.

Yellow means **Caution Zone!**
Add quick-relief medicine.

Red means **Danger Zone!**
Get help from a doctor.

Personal Best Peak Flow: _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from _____ to _____

Use these daily preventive anti-inflammatory medicines:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight Chest
- Coughing at night

Peak flow from _____ to _____

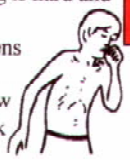
Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR PRIMARY CARE PROVIDER.

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well



Peak flow from _____ to _____

Take these medicines and call your provider now.

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

Get help from a provider now! Do not be afraid of causing a fuss. Your provider will want to see you right away. It's important! If you cannot contact your provider, go directly to the emergency room. DO NOT WAIT.
Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

HILL HEALTH CENTER

Provider's Signature: _____

Adapted from the National Initiative for Children's Healthcare Quality

An Action Plan for Patient Self-Management

1. Goals: *Something you WANT to do:*

_____

_____

_____

2. **Describe**

How: _____
Where: _____
What: _____ **Frequency:** _____
When: _____

3. Barriers: _____

4. Plans to overcome barriers: _____

5. Follow-Up: _____

Adapted from the Institute for Healthcare Improvement

Action Plan Tool for Patient Self-Management – EXAMPLE

1. **Goals:** *Something you WANT to do:*

   Begin exercising

2. **Describe:**

How:	*Walking*
Where:	*Around the block*
What:	*2 times*
Frequency:	*4 x/wk*
When:	*after dinner*

3. **Barriers:** *have to clean up; bad weather*

4. **Plans to overcome barriers:** *ask kids to help; get rain gear*

5. **Follow-Up:** *next visit – 2 months*

Adapted from the Institute for Healthcare Improvement

THE FIVE A's SELF-MANAGEMENT SUPPORT

ASSESS – ADVISE – AGREE – ASSIST – ARRANGE

PATIENT NAME _____ DATE _____

(Check ALL that apply)

___ **ASSESS**

- Patient completed assessment and received feedback on health behaviors

Notes:

___ **ADVISE**

- Personally relevant, specific recommendation for behavior change

Notes:

___ **AGREE**

- Document collaboratively set, realistic behavioral goals with patients

Notes:

___ **ASSIST**

- Worked with pt. to develop action plan, strategies, or problem solve
- Referred pt. to resource, counselor, or group to work on above

Notes:

___ **ARRANGE**

- Made follow-up contact within 2 weeks after setting behavioral goal
- Checked to see that pt. completed referral visit
- Obtained feedback on pt. progress from referral party or from patient

GENERAL NOTES:

Adapted from the White Mountain Research Group

HEALTHY CHANGES PLAN ~ SELF-MANAGEMENT SUPPORT TOOL

Organization Name: _____

Name: _____Date: _____

Phone: _____

The healthy change I want to make is (very specific: What, When, How, Where, How Often):

My goal for the next month is:

The steps I will take to achieve my goal are:

The things that could make it difficult to achieve my goal include:

My plan for overcoming these difficulties includes:

Support/resources I will need to achieve my goal include:

My confidence that I can achieve my goal: (scale of 1-10 with 1 being not confident at all, 10 being extremely confident) _____

Review date: _____ with _____

Adapted from the Institute for Healthcare Improvement

A Spread Planner

Leadership for Spread

- Is improvement in this area a key strategic initiative within the organization?

Improvement is a strategic initiative:	Circle: Yes No Unsure
If "No" establish top-level commitment before proceeding.	
If "Unsure" how can this be clarified?	
Actions:_____	
_____	
_____	
_____	

- Is there an executive(s) who is responsible for the spread?

Who: _____	
Is this person passionate about the change?	Circle: Yes No Unsure
Is success in spreading this improvement part of his/her goals/performance evaluation?	Circle: Yes No Unsure
Actions:_____	
_____	
_____	
_____	

- Is there a person or team who will manage the day-to-day spread activities?

Who: _____	
Does this person or team have sufficient time specifically dedicated to spreading this improvement?	Circle: Yes No Unsure
Actions:_____	
_____	
_____	
_____	

Adopted from the Institute of Healthcare Improvement, 2005

A Spread Planner
(cont.)

- Are the goals and incentives for the organization aligned with the new system?

What organizational goals relate to: _____

Are the goals sufficiently aligned with major organizational goals to motivate leaders and new adopters? Circle: Yes No Unsure

Actions: _____

_____

_____

_____

Set-Up for Spread

- What is the target population (e.g., which facilities, units, etc.)?

Target facilities, units, etc. _____

_____

_____

_____

- Is there a successful pilot site that has implemented the new system?

Successful site(s) : _____

How do you know the site is successful? (Be sure to review tests of change and results from pilot site.)

_____

_____

Are the elements of the new system packaged in a way that facilitates adoption in other sites? If not, what needs to be done?

_____

_____

Potential role of pilot site(s) in spreading to new sites: _____

_____

_____

A Spread Planner
(cont.)

- Who are the key groups who make the adoption decision in the target population (e.g. Surgeons, Primary Care Physicians, Nurse Managers, Schedulers)?

Target Groups: _____

_____

_____

_____

_____

- What is your initial strategy to reach all sites? (Include a brief statement of 1 to 3 concise sentences.) Considerations include:
  - Will certain components of the change be spread to all sites or will all the components be spread to certain sites?
  - What is the relationship of units to the pilot sites?
  - Where do champions exist or where can they be readily developed?
    - At the leadership level?
    - At the grass-roots level?

Initial Strategy: _____

_____

_____

_____

_____

- What are your plans to establish two-way communication between those leading spread and the pilot sites?
  - Are there existing venues you can use?
  - What new communication venues need to be created?
  - Who is responsible for monitoring the effectiveness of two-way communication?

A Spread Planner
(cont.)

Initial Strategy: _____

_____

_____

_____

_____

- What is the initial strategy for reward and recognition of participation and progress?

Initial Strategy: _____

_____

_____

_____

_____

- Where resources are available?

Initial Strategy: _____

_____

_____

_____

_____

Strengthening the Social System

- Who are the key messengers that will explain the new system to the target population?
  - How will you identify them?
  - What will you do to help them?
  - What technology will you use to help them?
  - How will you continue your relationship with them?
  - How will you provide feedback?

A Spread Planner
(cont.)

Initial Strategy: _____

_____

_____

_____

_____

- Can "communities of practice" (people with similar positions and responsibilities, e.g., physicians, nurses, technicians, clerks, etc.) be established to facilitate discussions among peers? Are these communities needed for your spread work?
  - How will you provide a time and place for people to interact?
  - What will motivate them to form communities of practice?
  - How will you encourage communication and feedback among the group?
  - How can you support them?
  - What technology will you use to help them?

Initial Strategy: _____

_____

_____

_____

_____

- What are the concerns of the front-line staff in the target population? How will these concerns be addressed?
  - How will you educate them about specific changes?
  - What will you do to enable them to see the big picture?
  - What technology will you use to help them?

Initial Strategy: _____

_____

_____

_____

Adopted from the Institute of Healthcare Improvement, 2005

A Spread Planner
(cont.)

- What tools or methods did the successful pilot sites use that can make it easier for the new teams to make the changes?
  - How will you transfer those tools, methods, and knowledge to the other teams?
    - How will you share documents?
    - How will you encourage new teams to hear from pilot site teams?
    - How will you enable an "all teach, all learn" environment?
    - How will you encourage pilot site teams to learn from new teams?

Initial Strategy: _____

_____

_____

_____

_____

- How will the leadership stay involved and connected to the front-line teams?

Initial Strategy: _____

_____

_____

_____

_____

Other Key Considerations for Successful Spread

Developing the Communication Plan

- How will awareness of the initiative be communicated?
  - Have the benefits been documented?
  - Is comparative data available?
  - What channels will be used to raise awareness in the target population?

A Spread Planner
(cont.)

- How will technical knowledge be communicated?
  - Have the potential changes and the ongoing learning been documented in a succinct format?
  - What face-to-face interactions are planned?
  - How will successful sites be involved to supply technical support?
- How will key measures be communicated to leadership?
- How will assessment of progress and results be communicated back to the pilot units?

Initial Strategy: _____

_____

_____

_____

_____

Developing the Measurement and Feedback System

- How will outcomes be measured?
- How will the rate of spread be monitored?
- Who will be responsible for collecting, plotting, and sharing the data?
- What information/reports will be used to monitor and refine the spread strategy?
- How will measures and analyses be fed back to the pilot units to support and encourage further progress?
- How will pilot units be rewarded and recognized for participation and progress?

Initial Strategy: _____

_____

_____

_____

_____

Adopted from the Institute of Healthcare Improvement, 2005

A Scorecard for Spread

How to Use the Scorecard

- The exercise is done as a table exercise with people sitting at tables.
- Write the name of a specific change/innovation in the box at the left.
- Have each person independently rate the change from the "spread target" point of view.

  Use a 1–5 scale:

  1 — change is very weak relative to this attribute
  3 — change is okay relative to this attribute
  5 — change is very strong relative to this attribute

- After each table has had a chance to evaluate the change, have a report out and group discussion of how the changes were rated in relation to each of the attributes. Pay particular attention to: (1) any item where there are significant differences in scoring among the group (e.g., 2s and 5s on the same item); and (2) scores of 1 or 2 for any of the items.
- Use these discussions to plan how to overcome barriers that are identified and develop an action plan for addressing these barriers.
- Teaching point is that each change differs on how easily it is likely to spread. Some may require specific communication messages or specific actions that a team can take to make it more likely to spread (e.g., make sure the test is visible and testable by others, simplify the instructions on how to do the change).

Definitions

Relative Advantage

- The degree to which an innovation is perceived as better than the idea it supersedes

Simplicity

- The degree to which an innovation is perceived as simple to understand and use

Compatibility

- The degree to which an innovation is perceived as being consistent with the existing values, experiences, beliefs, and needs of potential adopters

Trial Ability

- The degree to which an innovation can be tested on a small scale

Observables

- The degree to which the use of an innovation and the results it produces are visible to those who should consider it

	Relative Advantage	Simplicity	Compatibility	Trial Ability	Observables
Name of Innovation					

Plan, Do, Study, Act Worksheet

Plan—the change, predictions, and data collection

The change

What are we testing, and who is conducting the test?

Who are we testing the change on?

When are we testing?

Where are we testing?

Predictions

What do we expect to happen?

Data

What data do we need to collect?

Who will collect the data?

When will the data be collected?

Where will the data be collected?

Do—test (carry out the change), collect data, and begin analysis

What was actually tested?

What happened?

Observations:

Problems:

Study

Complete analysis of data, summarize what was learned, compare data to predictions:

Act

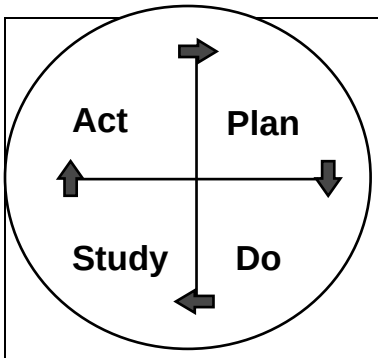
What changes should we make before the next test cycle?

What will the next test cycle be?

Are we ready to implement the change?

http://www.qualishealth.org/collaboratives/resources/pdsa_worksheet.doc

MODEL FOR IMPROVEMENT



CYCLE FOR LEARNING AND IMPROVEMENT
Objective:

PLAN:
Questions:

Predictions:

Plan for change or test: who, what, when, where

Plan for collection of data: who, what, when, where

DO: carry out the change or test; collect data and begin analysis.

STUDY: complete analysis of data; summarize what was learned.

ACT: are we ready to make a change? Plan for the next cycle.

Adapted from the Institute for Healthcare Improvement

PDSA Learning Table

Change Concept	Change Idea	Question that PDSA cycle will test	What will you do to test this?	How will you measure results of the PDSA cycle?	What have you learned from the cycle?

Adapted from the Institute for Healthcare Improvement

A Comparison of Group Visit Models

Decision Support

	Cooperative Health Care Clinic	Drop-In Group Medical Appointment	Continuing Care Clinic	Cluster Visits for Diabetes Care	Chronic Disease Self-Management Program	Support Groups
Patients	Elderly with one or more outpatient visits/month	Either mixed group or single diagnosis	Elderly with chronic condition OR diabetes on medication	Age 16-75 with HbA1c >8.5 % or none for 1 year	Ages 40 and up with heart disease, lung disease, stroke, or arthritis.	Widely used in all ages and many conditions for patients and/or caregivers.
Setting	HMO (Kaiser Colorado)	HMO (Kaiser Southern California)	HMO (Group Health Cooperative of Puget Sound)	HMO (Kaiser Northern California)	Community-based, (Churches, senior centers) or clinic	Community or Clinic based
Interval	Monthly group meetings of 25 patients	Set by provider team, depending on format. Weekly or monthly.	3 or 4 times/yr, 8 patients	monthly visits for 6 months with 10-18 patients	Seven weekly class sessions, 10-16 participants (revised version is six sessions)	Varies. Monthly is a typical interval. Most groups function well with between 8 and 20 members.
Staffing	Primary Care Provider RN Occas. Ancillary staff (pharmacy, PT, dietician)	Primary Care Provider, Medical assistant, Psychologist (some sites using SW or RN)	Primary Care Provider RN Pharmacist SW or RN for group	Diabetes nurse educator in consultation or by referral: podiatrist pharmacist psychologist nutritionist pharmacist primary care provider	Two volunteer lay leaders per course	Varies from peer led to professionally led. MSG=Mutual Support Group.
schedule	15 min. warm-up 30 min presentation 15 min "break" (providers circulate and triage) 15 min. Q&A	90 minutes total. MA does vitals, chart retrieval, Psychologist warm-up until provider arrives Interview pts in	½ day clinic with 45 minute group session in the middle. Patients spend 15 minutes each with pharmacist, MD,	two hour visit based on evidence-based protocol between-visit proactive phone calling	Each session is 2 ½ hours long, which includes a lengthy break. Sessions are interactive using return	Varies. Groups are typically considered either social support or educational with support. Some include

Adapted from Improving Chronic Illness Care, 2005 http://www.chroniccare.org

A Comparison of Group Visit Models

Decision Support
(Continued)

	30 min allotted for brief 1:1 with MD	room sequentially, provider does some "huddle" conversations with individuals while psychologist discusses topics with group.	and RN either before or after the group.	individual visits as needed (30% of patients used). Regular case review by primary care provider.	demonstration, modeling, brainstorming and problem solving. Telephone calls to encourage action plans by lay leaders, then between group members.	cognitive behavioral techniques (CBT).
Topics	Six topics determined by provider (evidence-based clinical priorities, such as immunizations, advanced directives), six topics determined by group.	Determined by attendees medical issues. Psychologist emphasizing commonalities, self-care, coping as much as possible.	Planned visit following evidence-based clinical priorities for geriatrics or diabetes. Group focused on self-management support.	Risk factor reduction, self-management, skills teaching (monitoring, insulin use) By patient request: exercise, sexual dysfunction, stress management, emotional concerns	Topics include exercise, cognitive sx mgmt techniques, nutrition, fatigue and sleep mgmt, use of comm. resources, use of meds, dealing with emotions, communicating with others, problem-solving, decision-making	Some offer no structure, some are highly structured.
Results	RCT and implementation data: decr. ER visits decr. specialist visits decr. hospital admits incr nurse visits and nurse calls decr. calls to MD decr. cost $14.79 PMPM	Anecdotal and non-comparison: impr. patient satisfaction impr. access impr. provider satisfaction	RCT: Elderly: incr. satisfaction no change in clinical outcomes. Diabetes: incr. preventive services incr. satisfaction with diabetes care incr. primary care visits but decr. specialty and ER	RCT: Decr. HabA1c by 1.3% improved self-efficacy incr. self-care practices impr. satisfaction lower hospital and outpatient utilization	RCT: Increased exercise Increased cognitive symptom management Improved self-reported health	Multiple RCT's: Decreased symptoms in depression for groups with both CBT or MSG, but CBT improved more. (Bright, 1999). Indications that telephone groups work as well as on-site groups in caregivers of head-

Adapted from Improving Chronic Illness Care, 2005 http://www.chroniccare.org

A Comparison of Group Visit Models

Decision Support

(Continued)

			visits improved outcomes with incr. attendance, incl. HbA1c.			injured pts (Brown, 1999). Education or education and peer support were superior to peer support alone in breast CA (Helgeson, 1999) CBT superior to MSG in IBS (Payne, 1995)
Citation	Beck et al:, JAGS 45:543-549, 1997. Coleman et al, Eff Clin Prac 4(2):49-57, 2002. Adaptation: Masley et al, FPM June 2000	Noffsinger E. Grp Prac Jrnl 1999;48(issues 1, 2, 3, 4, 6) Noffsinger E. The Permanente Jrnl 1999;3(3):58-67.	Coleman et al, JAGS 47:775-783, 1999 Wagner et al, Diabetes Care 24:695-700, 2001.	Sadur et al, Diabetes Care, 22(12):2011-2017, 1999.	Lorig et al. Medical Care 37:5-14, 1999. Lorig et al. Medical Care 39:1217-1223, 2001.	see above. Search terms self-help group and support group.
Guide available?	Yes On ICIC website contact John Scott, MD at University of Colorado John.scott@uchsc.edu FPM: http://www.aafp.org/fpm/20000600/33plan.html	Unknown	Yes On ICIC website contact Connie Davis at GHC, 206-287-2554 or davis.cl@ghc.org	Unknown	Manual for leaders, book for participants (Lorig et al, Living a Healthy Life with Chronic Conditions, Bull Publishing, 1997.)	Some voluntary organizations have materials, such as the American Stroke Association.
Information on use in other settings	Dr. Scott had HCFA review their model and HCFA has stated that this is a billable MD visit. FPM article describes coding for appropriate reimbursement, typically 99212, 3, or 4.	Some now calling "Doctor interactive group medical appointments." Currently being studied in clinical trial.	Widely used in Britain as a "mini clinic."	Anecdotally, many sites using this approach.	Adapted from Arthritis Self-Help Course. Also used in low back pain, HIV/AIDS, diabetes. More information at	No reimbursement available.

Asthma Flow Sheet

ASTHMA SEVERITY DIAGNOSIS *Rate symptoms/signs in each category; Severity Code corresponds with highest cell checked.*					
Daytime cough, wheeze, SOB, or chest tightness	**Nighttime cough, wheeze, SOB, or chest tightness**	**B2-Agonist Use**	**Impact on activity**	**FEV1 /PEF**	**Code Severity**
☐ All the time	☐ Frequent	☐ >7x/wk	☐ Interferes with any activity	☐ ≤60%	☐ **4 Severe Persist.**
☐ Daily	☐ ≥5x/month	☐ 7x/wk	☐ Interferes with mod. activity	☐ >60<80%	☐ **3 Mod. Persist.**
☐ 3-6x/week	☐ 3-4x/month	☐ 3-6x/wk	☐ Only with a lot of activity	☐ ≥80%	☐ **2 Mild Persist.**
☐ ≤ 2x/week	☐ ≤2x/month	☐ <2x/wk	☐ Not at all unless an attack	☐ ≥80%	☐ **1 Mild Intermit.**

TODAY'S CONTROL RATING (see Table III at charting station for rating explanation)				
☐ Very Poor	☐ Poor	☐ Fair	☐ Good	☐ Excellent

TODAY'S VISIT MEDICATION TREATMENT PLAN											
CONTROLLERS	**√**	**DOSE**	**FREQ**	**CONTROLLERS**	**√**	**DOSE**	**FREQ**	**QUICK-RELIEF**	**√**	**DOSE**	**FREQ**
Inhaled Corticosteroids				**Leukotriene Modifiers**				**Short-acting Beta-agonist**			
Fluticasone				**Montelukast**				**Albuterol** MDI90 mcg			
Flovent MDI 44 mcg				*Singulair* 4 mg chew.				*Proventil* MDI 90 mcg			
Flovent MDI 110 mcg				*Singulair* 5 mg chew.				*Ventolin* MDI 90 mcg			
Flovent MDI 220 mcg				*Singulair* 10 mg tab				***Maxair*** MDI 200 mcg			
Budesonide				**Long-acting Bronchodilators**				**Albuterol** neb soln. 2.5 mg/3ml prediluted			
Pulmicort Respules 0.25 mg/2ml				**Salmeterol**				**Albuterol** 0.5% neb soln.			
Pulmicort Respules 0.50 mg/2ml				*Serevent* MDI 21 mcg				**Levalbuterol**			
Pulmicort Turbuhaler 200mcg				**Mast Cell Stabilizers**				*Xopenex* 0.63mg/ 3ml neb soln			
Beclomethasone				**Cromolyn** neb. Soln. 20 mg/amp				***Xopenex* 1.25mg/ 3ml neb soln**			
Beclovent 42 mcg				*Intal* MDI 800 mcg							
Vanceril 42 mcg				**Spacers**				**Oral Steroids**			
Triamcinolone				*Aerochamber*				**Prednisone** 1, 2.5, 5, 10, 20, 25, 50 mg			
Azmacort 100 mcg				*Aerochamber* (mask)				**Prednisolone**			
Flunisolide				*Optichamber*				*Prelone* 15 mg/5ml			
Aerobid 250 mcg				*Inspirease*				*Pediapred* 5 mg/5ml			
				Space Chamber							

Asthma Education
Teaching provided by: _____, CHW LPN RN NP PA MD
Inhaler technique: ___ Explanation ___ Demo ___ Pt Re-demo ___ Sample
Inhaler/spacer technique: __ Explanation ___ Demo ___ Pt Re-demo ___ Sample.**Technique Adequate? __ yes __ no**
Peak Flow Meter: ___ Explanation ___ Demo ___ Pt Re-demo ___ Sample
___ Explanation of asthma ___ Action Plan/Self Management ___Trigger avoidance ___ Environmental control
Referral to Asthma Education Group: _____ Patient Goal: _____
Notes:

Patient Name	D.O.B.	HHC#

Adapted from the National Initiative for Children's Healthcare Quality

Asthma Assessment Flow Sheet

Notes	Vital Signs and Lung Function Tests
	Height: _____ Weight: _____ Resp.Rate: _____ Pulse: _____ Temp: _____ BP: _____/_____ Spirometry/FEV_1: _____ % Post-tx: _____ % Peak Flow: Pers.Best _____ Est. for Ht _____ Peak Flow Rate: _____#; _____% Post-tx PFR: _____; _____% Pulse Ox: _____%

Current Symptoms	Recent Daytime Sx's	Recent Nighttime Sx's	B2-Agonist Use
___ No Symptoms ___ Wheeze ___ Cough ___ Sputum ___ Chest tight/dyspnea ___ SOB ___ Other: _____	___ 0 days/week ___ 1-2 days/week ___ >2 days/week ___ Every day ___ Continual (multiple symptoms/day)	___ 0 x/month ___ 1-2 x/month ___ 3-4 x/month ___ >4 and <12 x/month (1-2 x/week) ___12 x/month (>3/week)	___ None ___ 1-2 days/week ___ 3-6 days/week ___ 7 days/week ___ *Avg. Puffs/Day*

ER Visits	Missed School	Home Peak Flow Rates	Triggers
(in the last month) ___0 ___1 ___2 ___3 ___4 ___>4 Hospitalizations in last year: _____	*(d/t asthma, last 2 weeks)* ___ None ___ 5-6 days ___ 1-2 days ___ 7-8 days ___ 3-4 days ___ 9-10days	Range: _____ ___ Green Zone ___ Yellow Zone ___ Red Zone ___ No PFM	___ No known ___ Cigarette smoke ___ Exercise ___ Dust ___ Mold ___ URI ___ Pollen ___ Pet: *Type*_____ ___ Weather change ___ Cockroaches Other:

Co-Morbidities	Impact on Activity	Environmental	Current Medications
___ Allergic Rhinitis ___ Eczema ___ Sinusitis ___ Obesity ___ GERD ___ *Other:* _____	___ No effect on any activity ___ May affect some activity ___ Activity often affected ___ Activity severely limited *Describe any activities affected:* _____	*Problems/Concerns:*	Has spacer? ___ yes ___ no. *Type:* **Med Adherence:** ___ Poor ___ Fair ___ Adqte

Physical Exam	Treatment at Visit
Chest/Respiratory: ___ Lungs clear to auscultation ___ Tight ___ Shallow breath sounds ___ Wheeze: *Describe* _____ ___ Retractions: *Describe* _____ ___ Prolonged Expiration ___ Nasal Flaring ___ Other sounds: *Describe* _____ **EENT:** **Skin:** **Other signs:**	Xopenex (levalbuterol) neb: ___ 0.63 mg/3ml ___ 1.25 mg/3ml Albuterol neb: ___ 2.5 mg/3ml ___ # of treatments ___ Prelone given – dose: _____ ___ Pt. Referred to ER: ___ Yale ___ St. Raphael's ___ Flu shot Other: ***Other diagnosis:***
Provider Signature:	***Other treatment:***

Follow-Up	Referrals
___ 2 weeks ___ 4 weeks ___ 2 months ___ 3 months ___ 6 months ___ other:	___ Allergist ___ Pulmonologist (Yale/St.Raph's) ___ VNA ___ Other:

Continued on Back (Severity Assessment, Treatment Plan, and Teaching)

Name:	**HHC #:**
Drug Allergies:	**DOB:**
Today's Date:	**Study Visit #:**

Adopted from Hill Health Center, 2005